Provider Communication

Subject:	Pharmacy: October 5, 2009 Update	**Priority:**	**High**
Date:	October 6, 2009	**Message ID:**	ACSBNR10062009_3

Dear Pharmacy Provider:

System Downtime:

The SXC claims processing system will be unavailable due to planned maintenance per the following:

- Wednesday, October 7th, between 2:00-4:00 a.m. EST
- Thursday, October 8th, between 3:30-6:00 a.m. EST

Claims needing to be submitted during these periods should be held until the maintenance is completed. Georgia Medicaid apologizes for any inconvenience this downtime may cause.

Inappropriate Use of Wellbutrin SR / Bupropion HCL SR for Smoking Cessation:

Effective October 1, 2009, claims submitted for Wellbutrin/bupropion SR will be subject to an automated review upon adjudication. The automated review will consist of looking back 90-days from the date of service for concomitant Selective Serotonin Reuptake Inhibitor therapy. Claims that do not meet the requirements of the automated review will be subject to prior authorization (PA). Providers may request a PA from the SXC Clinical Call Center at 1-866-525-5827.

Rebate Vendor Outreach to Enrolled Pharmacy Providers Announcement:

In an effort to proactively reduce point of sale payment errors, please be advised that you may receive a call from Goold Health Systems (GHS), the rebate vendor for the State of Georgia Fee-For-Service Medicaid Pharmacy Program. If you receive a call, you may be asked to explain the billing of a particular claim. The Departments' goal is to reduce common billing errors that may occur at the point of sale.

By verifying the pharmacy intent or correcting a billing error, GHS can mitigate downstream issues with rebate invoicing to manufacturers. This type of reconciliation may prevent a call to your pharmacy months after a claim was adjudicated

MOST FAVORED NATION (MFN) RATE

The Georgia Department of Community Health requires that pharmacy providers report their MFN rates annually and during the year when there are rate changes. This request is for 2009–2010 and will ensure proper provider reimbursement for pharmacy services. As a reminder the policy is as follows:

"602.1a MFN Rate Reporting"

At a frequency of at least annually, enrolled pharmacy providers must report their MFN rates in writing to the Medicaid Pharmacy Services Unit. Failure to report current MFN rate may result in recoupment of any overpaid fees". (Part II Policies and Procedures for Pharmacy Manual, 2008, p. VI-3)

Please complete and return the attached MFN Reporting form with your MFN rate. The form should be returned to Georgia Medicaid between September 1, 2009 – November 30, 2009. You may send it by fax to 404-657-5461 or to this address:

Department of Community Health
Pharmacy Services
2 Peachtree Street, N.W. 37th Floor
Atlanta, Georgia 30303

The MFN Rate Reporting Form may also be downloaded from www.ghp.georgia.gov → Provider Information → Documents and Forms → View Full List → Scroll to the "Most Favored Nations Rate Reporting Form".

If you have questions or concerns, please do not hesitate to contact the Department at (404) 656-4044.

Confidential

MFN Reporting Form

Please provide the information below using your pharmacy's letterhead, include all of the requested information and return via FAX to: Pharmacy Services @ 404-657-5461

Pharmacy Name_____

Address _____

City _____ State _____Zip code_____

Phone # _____Fax # _____e-mail_____

Name of Contact _____

Printed

NCPDP# _____ Medicaid # _____NPI # _____

Check one:

For Profit _____ Not for Profit_____

Most Favored Nation reimbursement rate:

Please note: CMO contracted rates, SHBP rates, and Medicare PDP rates should not be included when determining your MFN rate.

AWP - % + Dispensing Fee

Brand Discount is _____% Brand Dispensing Fee is $_____

Generic Discount is_____% Generic Dispensing Fee is $_____

MAC + $_____

_____ _____

Signature **Date**

It is imperative to notify the Medicaid office when there is a change in your MFN rate. See section 602.1a in Part II of the Pharmacy Policies and Procedures Manual on the ghp.georgia.gov website.

Coverage Changes For Insulin Syringes & Pen Needles Effective October 1, 2009:

Effective October 1, 2009 there will be a change in coverage as it relates to insulin syringes and pen needles. For a complete list of covered insulin syringes and pen needles (including applicable Georgia Maximum Allowable Cost (GMAC) prices) please refer to www.ghp.georgia.gov → Provider Information→ Pharmacy Services Overview → View Full Text → Other Pharmacy Documents → Covered Insulin Syringes and Pen Needles.

Quantity Level Limit for Insulin

Effective 10/01/2009, the quantity level limits (QLL) for Insulin will change from 60ml per 34-days to **40ml per 34-days**.

Requests to exceed these quantity level limits, or for any non-preferred Insulin product will require Prior Approval. Providers may request a PA from the SXC Clinical Call Center at 1-866-525-5827.

Quantity Level Limit For Triptans

The quantity level limits (QLL) for certain medications used to treat migraines will change from 18 tablets per 34-days to **9 tablets per 34-days**.

The medications affected by this change in limit include the tablet products of Amerge®, Axert®, Frova®, Imitrex®, Maxalt®, Relpax®, sumatriptan, Treximet® and Zomig®.

Requests to exceed these quantity level limits, or for any non-preferred product will require Prior Approval. Providers may request a PA from the SXC Clinical Call Center at 1-866-525-5827.

Important Update
DCH Decision Document

Listed below are Preferred Drug List changes for the State of Georgia Fee-For-Service Medicaid and PeachCare for Kids Programs

EFFECTIVE OCTOBER 1, 2009 or November 1, 2009 (see chart below)

As communicated in the past, DCH has a new rebate vendor, Goold Health Systems, working with the state to support our CMS and Supplemental Rebate programs. DCH has now concluded its analysis of supplemental rebate offers for the most recent round of bidding and PDL decisions for those categories involved in the bidding process are outlined below. Those drugs highlighted in red indicate a change from current PDL status. Several categories are up for discussion at the next Drug Utilization Review Board meeting and therefore they are not included in the decisions below. Those category decisions will be posted after DURB recommendations are received. Please note, this is not a full PDL listing and is not intended to include all covered drugs within a therapeutic category or provide a comprehensive list of therapeutic categories. For a full listing of our PDL, go to www.dch.georgia.gov/pharmacy and select the "Preferred Drug Lists" option.

ANALGESICS - MISC.			**Effective Date: 10/1/09**
	Preferred	**Non-Preferred**	
	CEPHADYN	LEVACET TAB	
ANDROGENS / ANABOLICS			**Effective Date: 10/1/09**
	Preferred	**Non-Preferred**	
	ANDROGEL	TESTRED	
	ANDROGEL PUMP	TESTIM	

	ANDRODERM PATCH		
	ANDROXY		
	DANAZOL		
	DELATESTRYL		
	DEPO-TESTOSTERONE		
	OXANDROLONE		
	TESTOSTERONE CYPIONATE		
	TESTOSTERONE ENANTHATE		
ANGIOTENSIN II RECEPTOR ANTAGONIST & COMBO			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	AVALIDE	ATACAND	
	AVAPRO	ATACAND HCT	
	BENICAR	TEVETEN HCT	
	BENICAR HCT	TEVETEN	
	COZAAR	AZOR	
	DIOVAN		
	DIOVAN HCT		

	EXFORGE		
	EXFORGE HCT		
	HYZAAR		
	MICARDIS		
	MICARDIS HCT		
	SPIRIVA		
ANTICOAGULANTS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	ARIXTRA	COUMADIN	
	LOVENOX INJ		
	FRAGMIN INJ		
	WARFARIN SODIUM		
ANTICONVULSANTS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	BANZEL	DILANTIN	
	CARBAMAZEPINE, - ER/SR	DIVALPROEX SODIUM	
	CARBATROL	GABITRIL	
	CELONTIN	KEPPRA, -TAB/SOLN	

	DEPAKOTE	KEPPRA XR	
	DEPAKOTE ER	LAMICTAL XR / ODT	
	DEPAKOTE SPRINKLES	LAMICTAL XR / ODT KITS	
	DIASTAT ACUDIAL	LAMICTAL (EXCEPT 2MG STRENGTH)	
	DIASTAT PEDIATRIC	LAMICTAL CHEWABLES	
ANTICONVULSANTS (continued)			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	DILANTIN INFATABS	LAMICTAL KITS	
	FELBATOL	NEURONTIN	
	GABAPENTIN	STAVZOR	
	LAMICTAL 2MG (ONLY)	TEGRETOL, -XR	
	LAMOTRIGINE	TOPAMAX TABS	
	LAMOTRIGINE CHEWABLES	TOPIRAMATE SPRINKLE	
	LEVETIRACETAM, TAB/SOLN	TRILEPTAL TABS	
	LYRICA	VALPROIC ACID	
	OXCARBAZEPINE	VIMPAT	
	PHENYTOIN	ZONEGRAN	
	TOPAMAX SPRINKLE		

	TOPIRAMATE TABS		
	TRILEPTAL SUSP		
	ZONISAMIDE		
ANTIDEPRESSANTS-SELECTIVE SEROTONIN REUPTAKE INHIBITORS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	CITALOPRAM HBR, -SOLN	CELEXA	
	FLUOXETINE HCL	LUVOX CR	
	FLUVOXAMINE MALEATE	PAROXETINE ER	
	LEXAPRO	PEXEVA	
	LEXAPRO SUSP	PAXIL	
	PAROXETINE, -SUSP	PROZAC, -WEEKLY	
	PAXIL CR	RAPIFLUX	
	SERTRALINE HCL, -SOLN	SARAFEM	
		SELFEMRA	
		ZOLOFT	

ANTISPASMODICS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	DETROL	DITROPAN XL	
	DETROL LA	OXYBUTYNIN ER	
	ENABLEX		
	FLAVOXATE		
	OXYBUTYNIN		
	OXYTROL		
	SANCTURA, -XR		
	TOVIAZ		
	VESICARE		
ATYPICAL ANTIPSYCHOTIC DRUGS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	EQUETRO	ABILIFY	NOTE: current INVEGA and SEROQUEL XR users will be grandfathered
	GEODON	CLOZAPINE	

	RISPERIDONE TAB/ ODT	CLOZARIL	
	SEROQUEL, immediate release formulations	FAZACLO	
		INVEGA	
		RISPERDAL TABS/SOLN	
		RISPERDAL CONSTA	
		RISPERDAL M-TABS	
		SEROQUEL XR	
		SYMBYAX	
		ZYPREXA, -ZYDIS	
		ZYPREXA INJ	
BETA ADRENERGICS SHORT ACTING INHALERS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	MAXAIR AUTOHALER	ALUPENT	
	PROAIR HFA	PROVENTIL HFA	
	VENTOLIN HFA	XOPENEX HFA	

DIABETIC - MEGLITINIDES			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	PRANDIN	PRANDIMET	
	STARLIX		
DIABETIC - ORAL BIGUANIDES			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	FORTAMET ER	GLUMETZA ER	
	METFORMIN HCL		
	METFORMIN HCL ER		
	RIOMET		
DIABETIC - THIAZOL / BIGUANIDE COMBO			Effective Date: 11/1/09
	Preferred	Non-Preferred	
		ACTOPLUS MET TAB	
		AVANDAMET TAB	
		AVANDARYL TAB	
		DUETACT	

DIABETIC - THIAZOL			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	ACTOS 15MG	ACTOS 30MG, 45MG	
		AVANDIA	
ENDOTHELIN RECEPTOR AGONISTS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	LETAIRIS		
	TRACLEER		
ERYTHROPOEISIS STIMULATING AGENTS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	PROCRIT	ARANESP	
		EPOGEN	
GI - INFLAMMATORY BOWEL AGENTS			Effective Date: 11/1/09

	Preferred	Non-Preferred	
	ASACOL 400MG DR	ASACOL HD 800MG	
	PENTASA 250MG CR	PENTASA 500MG CR	
	CANASA	LIALDA	
	APRISO		
	SFROWASA		
GI - MISC.			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	MOVIPREP	HALFLYTELY	
	RELISTOR		
GI - PROTON PUMP INHIBITOR			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	KAPIDEX	ACIPHEX	
	NEXIUM	OMEPRAZOLE	
	PREVACID (moves to NP on 1/1/10)	PANTOPRAZOLE SODIUM	
		PREVACID SOLUTAB	
		PRILOSEC	

		PROTONIX	
		ZEGERID	
HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS AND CALCIMIMETICS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	ZEMPLAR	SENSIPAR	
		HECTOROL	
INFLUENZA AGENTS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	RELENZA		
	TAMIFLU		
INSULIN			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	HUMALOG	APIDRA	
	HUMALOG MIX 50/50		

	HUMALOG MIX 75/25		
	HUMULIN 50/50		
	HUMULIN 70/30		
	HUMULIN N		
	HUMULIN R		
	HUMULIN R U-500		
	LANTUS		
	LEVEMIR		
	NOVOLIN INJ 70/30		
	NOVOLIN N INJ U-100		
	NOVOLIN R INJ U-100		
	NOVOLOG INJ 100/ML		
	NOVOLOG MIX INJ 70/30		
INSULIN PENFILLS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	LANTUS INJ SOLOSTAR	APIDRA OPTICLIK	
	LANTUS INJ OPTICLIK	HUMALOG PENS & CARTRIDGES	
	NOVOLOG INJ PENFILL	HUMULIN PENS & CARTRIDGES	
	NOVOLOG MIX INJ FLEXPEN		

INSULIN PENFILLS (continued)			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	NOVOLOG INJ FLEXPEN		
	LEVEMIR INJ FLEXPEN		
	NOVOLIN R INNOLET		
	NOVOLIN 70/30 INNOLET		
	NOVOLIN R U-100 PENFILL		
	NOVOLIN N U-100 PENFILL		
	NOVOLIN 70/30 PENFILL		
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--TABS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	MAXALT-MLT	AMERGE	
	FROVA	AXERT	
	SUMATRIPTAN generic	MAXALT Tablet	
	IMITREX	MIGRANAL NS	
		RELPAX	
		TREXIMET	

		ZOMIG, -ZMT	
MUSCLE RELAXANTS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	DANTROLENE SODIUM	AMRIX	
		SKELAXIN	
		SOMA	
NARCOTICS - MISC.			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	VARIOUS GENERICS	FENTANYL ORAL	
	SUBOXONE	FENTORA	
	SUBUTEX	PRIMALEV	
		REPREXAIN	
		XOLOX	
		ZAMICET	
NARCOTICS-LONG ACTING			Effective Date: 10/1/09

	Preferred	Non-Preferred	
	KADIAN 20MG CR	AVINZA CAPSULE	
	KADIAN 50MG CR	FENTANYL PATCH	
	KADIAN 100MG CR	KADIAN 200MG CR	
	KADIAN 30MG CR	KADIAN 80MG	
	KADIAN 60MG CR	OPANA ER	
	KADIAN 10MG CR CP24	ORAMORPH SR	
	DURAGESIC	OXYCODONE HCL ER	
	MORPHINE SULFATE SA	OXYCONTIN	
OP. BETA - BLOCKERS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	COMBIGAN	BETIMOL	
	BETAXOLOL HCL	BETAGAN	
	BETOPTIC-S	ISTALOL	
	CARTEOLOL HCL	TIMOPTIC, - XE	
	LEVOBUNOLOL HCL		
	METIPRANOLOL		
	TIMOLOL MALEATE		

OP. MAST CELL STABILIZERS			Effective Date: 11/1/09
	Preferred	Non-Preferred	
	CROMOLYN SODIUM	ALAMAST	
		ALOCRIL	
		ALOMIDE	
OP. NSAIDS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	ACULAR SOLN	NEVANAC SUSP	
	ACULAR PF SOLN	VOLTAREN	
	ACULAR LS SOLN	XIBROM	
OSTEOPOROSIS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	ALENDRONATE SODIUM	ACTONEL	
	CALCITONIN-SALMON	BONIVA	
	ETIDRONATE DISODIUM	DIDRONEL	
	EVISTA	FORTEO	

		FORTICAL	
		FOSAMAX, - +D	
		MIACALCIN	
PHOSPHATE BINDERS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	FOSRENOL	ELIPHOS	
	RENAGEL		
	RENVELA		
	PHOSLO		
STATIN - LOW POTENCY			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	LESCOL, -XL	ADVICOR	
	LOVASTATIN	ALTOPREV	
	PRAVASTATIN	MEVACOR	
		PRAVACHOL	
TNF BLOCKERS			Effective Date: 11/1/09

	Preferred	Non-Preferred	
	CIMZIA	ENBREL 50MG	
	HUMIRA	HUMIRA CROHN'S STARTER KIT	
	ENBREL 25MG ONLY	KINERET	
		REMICADE	
		SIMPONI	
TOPICAL - ACNE PREPARATIONS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	AVITA	ACZONE	
	BENZACLIN	ATRALIN	
	BENZACLIN GEL 1-5%	AVAR	
	BENZOYL PEROXIDE CLEANSER	AZELEX	
	DUAC, - CS	BENZACLIN KIT	
	METROCREAM	BENZOYL PEROXIDE PADS	
	METRONIDAZOLE	BREVOXYL	
	METROGEL	DIFFERIN	
	METROLOTION	EPIDUO	
	NUOX	FINACEA	

	TAZORAC	NEOBENZ	
	TRETINOIN CREAM/GEL GENERIC	NORITATE	
		OSCION	
		TRIAZ	
		ZIANA	
		ZODERM	
TOPICAL - ANTINEOPLASTICS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	FLUOROURACIL	SOLARAZE GEL	
		EFUDEX	
TRIGLYCERIDE LOWERING AGENTS			Effective Date: 10/1/09
	Preferred	Non-Preferred	
	GEMFIBROZIL	ANTARA	
	TRICOR	FENOFIBRATE	
	TRILIPIX	FENOGLIDE	
		LIPOFEN	

		LOFIBRA	
		LOPID	
		LOVAZA	
		TRIGLIDE	

Please share all of this information with appropriate staff. If you are the corporate office of a chain pharmacy, please provide this information to each of your stores located in Georgia.

We thank you for your continued service and participation in the Georgia Medicaid & Peach Care for Kids Programs.

Division of Medical Assistance
Pharmacy Services Unit
404-656-4044